1

The Urgent Need for Competent and Compassionate Emotional Healthcare Services with Pregnant Women and their Children: Replacing Prescription Therapy and the Abuse of Selective Serotonin Reuptake Inhibitors (SSRIs) with Drug-Free Therapeutic Alternatives, July 31, 2018

Author: Dr Pamela Beth Collman, Licensed Psychologist

By virtue of the mind and body state of being pregnant, pregnant women may believe they have less need for supportive emotional health services during this challenging phase of life. They may be inclined to minimize their needs or the needs of their unborn child. As each pregnancy is unique, this can be true for multiparous or primiparous mother's-to-be. Conversely, pregnant women may demonstrate sincere appreciation of even the most modest of emotional health interventions and kind acts of other people. In fact, evidence now exists that pregnancy in modern society leads to long-lasting changes in the brains of women (Hoekzema, Barba-Muller, Pozzobon et al, 2016), changes that may or may not be beneficial to mothers' emotional health or to the demands of child rearing.

Currently, the research on adverse effects of gestational exposure to Selective Serotonin Reuptake Inhibitors (SSRIs), a class of frequently and internationally prescribed psychiatric medication, continues to amass. Moreover, this research now encompasses a broad range of associated psychopathology and neurodevelopmental anomalies. This range of associations includes: altered fetal brain development and impaired brain maturation in preterm neonates (Podrebarac, Duerden, Chau et al, 2017) ; risk of preterm birth (Podrebarac et al, 2017); risk of major congenital malformations (Berard, Zhao & Sheely, 2018) ; newborns facing an opiod like drug/SSRI withdrawal syndrome (Alehan et al, 2008; Klinger & Merlob, 2008); disruptions in normal fetal sleep patterns with suppressed REM (Morrison et al, 2001); structural right hemisphere neurodevelopmental anomalies involving grey matter and white matter structures and connectivity (Lugo-Candelas, Cha, Hong, et al, 2018); to associations with autism (Schendel, 2017), autism without intellectual disability (Rae et al, 2017) and communication disorders(Weikum, Oberlander, Hensch & Werker, 2012; Raminsky & Burt, 2017).

A relationship between gestational exposure to antidepressants and higher incidence or risk of congenital heart defects was detected over a decade ago (Berard, 2007; Sadler, 2011). More recently, research was undertaken with a sizable Quebec cohort of 18,487 pregnant women, 3,640 of whom had been exposed, during their first trimester, to one of six different serotonin altering antidepressant. These six antidepressant medications were: (1) Paxil (paroxetine); (2) Zoloft (sertraline); (3) Celexa (citalopram); (4) Prozac (fluoxetine); (5) Luvox (fluvoxamine); and (6) the tricyclic Elavil (amitriptyline). Of these six antidepressants, each was found to be associated with higher risk of distinct organ-specific defects. These defects included cardiac, musculoskeletal, digestive, respiratory, craniosynostosis and defects of the eye, ear, face and neck. Only one medication, Celexa, demonstrated a statistically significant risk of major congenital malformations (Stiles, 2017). Celexa, an SSRI, may increase the risk for suicidal thoughts or behavior and may also be lethal when ingested during an overdose.

An abundance of animal research evidencing the deleterious impact of gestational SSRI exposure to the offspring of mammalian species has provided more conclusive findings. Such animal research more definitively demonstrates gestational SSRI exposure with associated anomalous brain morphology and connectivity (Nietzer, Bonn, Jansen et al, 2011; Wellman, Izquierdo, Garret et al, 2007). Only recently has research with full-term human infants revealed findings consistent with animal research: human infant brain developmental anomalies in precise brain regions essential to the central nervous system processing of emotion (Lugo-Candelas et al, 2018 and more specifically to brain circuitry and connectivity that may confer risk of developing anxiety disorders later in life.

Despite the growing international consensus on this crisis, medical professionals continue to liberally prescribe SSRI's to pregnant women. Moreover, skeptics persist by raising alarm that untreated maternal depression and/or untreated perinatal maternal anxiety present risk of substantial neurodevelopmental consequences to the unborn

2

child (Robinson, 2013; Robinson, 2015). What theses myopic skeptics fail to acknowledge is that alternative effective emotional health treatment for symptoms of depression and/or anxiety in adult females are readily available. These services include cognitive-behavioral and various other evidence-based approaches that fall within the category of traditional psychotherapy.

During pregnancy, a woman's perception of her needs for or ability to benefit from participation in emotional health care services may lack accuracy or agreement with experts. One reason for this is the need to better understand the emotional experiences of pregnant women and develop evaluation tools relevant to and specifically designed for use with this population. The recent research finding that women's brains are significantly altered in some detectable way following the birth of a child (Hoekzema, Muller, Pozzobon et al, 2017) very likely has a psychological component that researchers have yet to uncover. Psychological tests that address the unique perspective and emotional experiences of pregnant women is of tantamount importance to competent emotional health care with this population as is the development of screening tools that facilitate diagnostic accuracy and timely treatment referrals.

The research of Dipietro and colleagues (Dipietro, Ghera, Costigan & Hawkins, 2004) found that physically and emotionally healthy pregnant women tend to experience more "intense" mood states. These intense mood states concern both negatively and positively valenced emotions. Dipietro and colleagues were also able to tap into the unique daily experiences of delight and joy that healthy pregnant women commonly experience. Standard measures of psychopathology typically inquire about the presence and severity or intensity of depressive and anxious symptoms, rather than joyful or happy emotional experiences. Therefore applying these traditional diagnostic measures to a population of exclusively pregnant women will tend to produce substantial false positive diagnostic errors. Such false positive errors have the potential to result in more frequent prescription therapy with the SSRI's. As serotonin plays a complex, multifaceted critical role of early brain development, false positive errors can have dire consequences. For a woman in the early stages of a first pregnancy to unnecessarily begin a trial of SSRI medication, even for a very brief duration, fetal exposure may coincide with neurogenesis. This unfathomably rapid, seemingly explosive production of countless neurons and their immediate commencement into the intricate migration process to seek their correct destination in brain development represents a sensitive or critical developmental period. Interference with neurogenesis, by virtue of being a sensitive if not critical developmental stage, can result in permanent brain damage. Clearly researchers and clinicians must rethink administering standard diagnostic tests and generic clinical interviews to pregnant women, when evaluating their emotional health care needs.

Researchers have identified a tendency of emotionally and physically healthy pregnant women to endorse items specifically inquiring about pregnancy fears and worries in the direction of anxious pathology. They have named this unique type of concern "pregnancy anxiety" or "pregnancy specific anxiety" and developed a self-report measure of it. Pregnancy specific anxiety tends to be highest in pregnant mothers carrying a first child, especially in their third trimester (Madhavanprabhakaran et al, 2015; Lee et al, 2007; Teixeira et al, 2009) Pregnant women have understandable fears about childbirth, a potentially life threatening life event for both a pregnant woman and her unborn child or children. The medical discipline of obstetrics has one of the highest annual malpractice insurance rates for medical doctors in the United States, and for good reasons.

Even if non pharmaceutical therapeutic services were accessible, convenient, affordable and supportive in nature, treatment barriers might preclude a pregnant woman from seeking emotional health treatment. Stigma, cultural taboos, and anticipation of negative consequences for divulging fears or symptoms of psychopathology are some obvious obstacles. Perhaps less conspicuous are employment demands that leave little time or perceived choice to shop for a therapist. The sad fact is that currently pregnant women of any age or stage of maturity have very few emotional healthcare options "routinely" made available to them. Obstetrics clinics with an emotional health screening protocol for pregnant patients may not be prepared to offer more than prescription

3

pharmacotherapy in their busy practices. Such a narrow range of highly accessible emotional healthcare options undoubtedly perpetuates the frequent reliance on medication only interventions, typically with the SSRIs.

A lengthy track record of research concerning the deleterious effects of maternal stress and anxiety on pregnant women and their offspring does exist. While this knowledge base is comprehensive and fairly conclusive, translation into non pharmacological interventions of assistance remains to be accomplished, with very few exceptions. Galvin and colleagues boldly suggested that obstetrics practices consider partnering with specific mental health clinics to address the emotional health needs of pregnant patients (Gaynes, Galvin, et al, 2005). Mostly, however, the vigorous and longstanding research on stress during pregnancy has not yet benefitted expectant mothers and their offspring. It has done no more than expose the growing and gaping divide between researchers and clinicians, professionals who seemingly practice with no meaningful collaboration. When these two groups of professionals do begin to collaborate, they will likely concur that pregnant women and their offspring deserve emotional health services that are relational in nature.

The vast research on maternal stress during pregnancy has failed to change any basic clinical practices. The research examining the effectiveness of specific types of traditional therapy with pregnant patients is just now beginning to blossom. According to meta analytic research comparing group therapy with individual therapy of two types, group psychotherapy was the least effective at reducing depressive symptoms when symptoms were measured pretreatment and then again post treatment (Sockol, 2015). This research study concluded that more research was needed to ascertain which of the two types of individual therapy may be more beneficial for pregnant women: Interpersonal Therapy (IPT) or Cognitive Behavioral Therapy (CBT). IPT was equally or even more beneficial than CBT for pregnant women with depressive symptoms, according to this meta analytic research. IPT has demonstrated effectiveness in the treatment of Major Depressive Disorder while CBT can be quite effective for successfully treating anxiety and depressive disorders. Both IPT and CBT can be time limited, and thus accommodate patients who need longer treatment as well as those who do not. While CBT works by altering a patient's maladaptive thought patterns and associated decisions, IPT more specifically addresses several areas of a patient's life, including social support, coping with life stressors, and navigating interpersonal relationships.

The extent to which either IPT or CBT are "relational" in nature, offering patients an experience of a safe place to explore problem areas they deem important in the context of a non judgmental therapeutic relationship with a professional, depends on the individual therapist. Long term relational therapy has the potential to provide patients with the sometimes novel experience of an emotionally healthy relationship, free of exploitation and agendas that are not in the best interest of the patient. Such therapy can be particularly helpful for women who have mostly experienced dysfunctional or abusive relationships. Research continues to demonstrate that specific qualities of the treating clinician, including warmth and friendliness, flexibility, being respectful, honest, showing genuine interest and investment in the patient…… can be more important than specific evidence-based techniques to successful outcome (Ackerman & Hilsenroth, 2002; Wampold & Imel, 2015).

General therapy skills that are not specific to a particular evidence -based treatment or technique are also very instrumental to successful psychotherapy. These general therapy skills include: facilitating the patient's expression of affect; being supportive; and providing accurate interpretations (Ackerman & Hilsenroth, 2002; Wampold & Imel, 2015). These therapist qualities or characteristics and general skills facilitate the clinician patient therapeutic alliance. Given that pregnant women are preparing for a lifelong relationship with the child they are bearing, a relational approach seems to be a wise choice. Relational therapy with a clinician who has mastered the qualities that predict successful psychotherapy outcome is recommended at this time over specific types of therapy. The treating clinician, however, must be familiar with the research and knowledge base regarding the unique set of emotional health needs of pregnant women. Ideally, the best choice of treating clinician may be a professional who also has extensive experience with infants and children younger than five years of age. Additionally, a

4

clinician who can incorporate traditional attachment therapy and parenting interventions would be able to work successfully with the emotional health deficits of very young children.

Surprisingly, few published research studies were identified that evaluated the provision of traditional couples or marital therapy with pregnant women and their partner. Pregnancy can present an excellent opportunity to strengthen a marital relationship or facilitate a couple's ability to work effectively as a team in the face of daunting challenges. Couple's work may assist men to more easily prepare for and begin to establish their role as father of an infant. It can present opportunities to build skills in the mutual provision of emotional support, communication, and working through sensitive problems in a safe environment with professional guidance. Beginning couples therapy during pregnancy allows parents to address marital conflict and dissatisfaction. Couples intervention may buffer against marital dissatisfaction after the arrival of a first child (Shapiro, Gottman, Carrere, 2000). Pilkington and colleagues (2015) conducted a systematic review and meta-analysis of 120 published research studies examining depression and anxiety in parents-to-be. This review indicated sound evidence that specific partner factors, namely emotional closeness and global support, can protect against both perinatal depression and anxiety. In a Delphi consensus study, two panels of distinct expertise in perinatal mental health each endorsed at least 80% of 214 recommended ways that partners can provide each other with mutual support (Pilkington, Milne, Cairns & Whelan, 2016). Among the criticisms were that research in this arena has yet to materialize with regard to specific actions parents can and do implement (Pilkington et al, 2016). The 2016 Delphi consensus study has nonetheless spurred the creation process for a set of guidelines on how parents can provide mutual support with the goal of preventing depression and anxiety during pregnancy.

Exercise therapy is gaining popularity as a sole intervention or adjunctive treatment for symptoms of depression, though not yet for the treatment of anxiety. The benefits of exercise therapy during pregnancy is not yet established and lacks published research data to confidently recommend it as an effective emotional health intervention for depression. Some of the reasons exercise therapy may be especially suited as an emotional health intervention for pregnant women include its accessibility, the concomitant physical health benefits to the mother, and the potential health benefits for the fetus and for the success of the birth process. Four months of supervised aerobic exercise therapy with adults suffering from major depression had comparable effectiveness to SSRI pharmacological treatment with sertraline (Blumenthal, 2007). The efficacy of exercise therapy as a treatment modality for major depression in adults shows good promise but remains to be tested with a pregnant population. Research is currently investigating specific types of exercise therapy (aeorobic, anabolic resistance training, weight lifting, supervised exercise, in-home exercise therapy, socially supportive exercise, longterm exercise, yoga, tai chi…) for therapeutic use with specific populations.

Despite the plethora of research on the adverse effects to offspring of maternal stress and anxiety, published research on stress management interventions with pregnant women is scant. To improve standards of practice that address emotional health care needs of pregnant women, it would seem facile and expedient to offer on-site stress management services at obstetrics clinics. Family Nurture Intervention in the Neonatal Intensive Care Unit (NICU) has been found to be an effective program for diminishing symptoms of anxiety and depression among mothers of preterm infants (Welch, Halperin, Austin, Stark, Hofer, Hane & Myers, 2015). The family nurture intervention is an important accomplishment as the environmental conditions of the NICU remain unmodified despite a growing premature infant population. These conditions are at the very least " harsh" and not designed with infants' and parents' emotional health care needs in mind.

Research on popular emotional health approaches such as mindfulness and even positive psychology are in their infancy, with published data consisting of online interventions. Nutritional protocols continue to be used in the treatment of a broad range of mental health disorders (Walsh, 2012) The potency of some of these protocols suggests that they best be utilized when planning for a pregnancy or possibly even prior to infertility treatment. Transcranial Magnetic Stimulation (TMS) is a drug free option for pregnant women experiencing moderate to

5

severe depression. Pregnant women tend not to be open to participation in this type of emotional health treatment, according to survey research by Kim and colleagues (Kim, Sockol, Barber, Moseley et al, 2010). These researchers found that when surveyed pregnant women were provided with effective psychoeducational information about TMS in the form of an video, they became more willing to consider it as an intervention option (Kim et al, 2010). More severe depression has typically been treated by a combination of psychiatric medication and frequent psychotherapy. Women who rely only on an SSRI to manage their symptoms of depression and anxiety would not be classified as experiencing severe or even moderate depression. SSRI's, however, are frequently used to treat symptoms of a wide variety of anxiety disorders and symptoms of these disorders in conjunction with depressive symptoms. SSRI's may also be used to maintain treatment gains.

The research investigating negative sequelae from the use of SSRI antidepressants during pregnancy and lactation demonstrate a global consensus that prescription medication therapy during pregnancy poses longterm, disturbing emotional health effects in offspring exposed gestationally or soon after birth (Dubovicky, Belovicova, Csatlosova & Bogi, 2017). Technologically savvy research exemplified in Lugo-Candelas and colleague's (2018) recent work, can no longer be ignored, trivialized or dismissed by researchers and clinicians, an unfortunate pattern of professional irresponsibility. The price tag of a simple and expedient pharmacological response by medical professionals to highly complex problems of an intricate interdisciplinary nature is staggering when one considers the sheer number of children impacted since the introduction of the SSRIs in 1987! The media needs to apprise the public of these authentic dangers and relevant professionals must resurrect policies of full informed consent. Pregnant women deserve to routinely be offered alternative therapeutic approaches to prescription SSRI therapy at the earliest possible time during the course of pregnancy or family planning.

Emotional health interventions for maternal anxiety and depression are effective and available. The panorama of nonpharmaceutical therapeutic interventions, according to current published research, is wide. The biggest barrier may be the absence of interdisciplinary collaborative assessment and treatment efforts when providing healthcare to pregnant women. Research and clinical practice continue to utilize standard tests and screening instruments that are likely to misdiagnose clinical anxiety and depression in pregnant women. At the very least, this will result in missed opportunities to intervene with pregnant women in critical need of emotional health services, or to unnecessarily prescribe an SSRI to a pregnant woman. The "diversity" of symptomatology regarding antenatal maternal symptoms of depression and anxiety must also be addressed by future research. Experienced clinicians in outpatient settings regard the comorbid symptoms of anxiety and depression among adult female patients as a frequently encountered constellation. Whether this constellation may be a harbinger of major mental illness or merely reflects depressive symptoms emerging when symptoms of a recurring anxiety disorder such as panic or obsessive compulsive disorder resurface. Conclusions of leading researchers gingerly state that the association between prenatal SSRI exposure and fetal brain development is "particularly in brain regions critical to emotional processing" (Lugo-Candelas et al, 2018). Can we afford to gamble with this crisis any longer?

6

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7

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